REQUIEM OR REVEILLE: PSYCHIATRY'S CHOICE*

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THE hazard of selective history such as this essay was made clear some years ago in the London *Times:*

Then there was a schoolmaster setting essays on Alfred the Great. He urged upon his pupils no mention of the cake-burning episode as being irrelevant to the main thread of our rough island story. The resultant offerings included one which ran: Alfred fought a big battle against the Danes. He lost. He then ran into a wood, where he found a woman living in a hut. He went inside. What went on afterwards, I'm not to mention.

It is said that psychiatry is dead or at least dying, and that its great days are past. William Faulkner told us that the past is never dead, that it is not even past. But what may be past or passing is the more limited professional role which psychiatrists played earlier in this century. We are more numerous, more diverse in function, and society calls upon us to serve many needs, for some of which we are not prepared. It is said that we deal with myths, that mental disorders are myths imposed and nourished by a harsh society. Obviously, one of the most human of our characteristics is variability, and, even within reasonably homogeneous groups, behavior patterns are distributed widely. Yet, within each group certain patterns emerge which members of the group interpret as illnesses. Jane Murphy's recent report[1] of systematic data from Eskimo and Yoruba groups and information from several other cultures question the labeling theory. She concludes: "Rather than being simply violations of the social norms of particular groups, as labeling theories suggest, symptoms of mental illness are manifestations of a type of affliction shared by virtually all mankind." Of course there are myths. There have always been and probably always

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will be myths about health and sickness, particularly about mental illness. How many in this, our age of enlightenment, could have predicted such popular interest in the book and film "The Exorcist" and their sanction by the clergy?

One matter which I believe is more substance than shadow is the modern psychiatrist's concern about his professional role. This concern is illustrated clearly by the following selection of titles and comments from papers recently published in professional journals:

"Heaven protect the patient from any therapist who has a political position and a single form of treatment." "Psychiatric therapy often reflects the bias of the therapist and not the needs of the patient." "We have lost our boundaries." "We are over-regulated and over-managed." "There is an anti-intellectual movement promoting craftmanship at the cost of scholarship through truncating the undergraduate medical curriculum, eliminating the internship, and reducing the residency." "Somebody has to put the whole person together again." "Psychiatrists are found deficient in knowledge of psychotropic drugs." "There is a false egalitarianism obscuring and denying the differences in education, knowledge, skill, and responsibility between professionals and paraprofessionals in the interdisciplinary care of psychiatric patients." "Psychiatrists see their specialty returning to the mainstream of medicine." "The law doesn't trust psychiatry." "Patients are dying with their rights on." "Are you a psychiatrist or a real doctor?" "Is liaison psychiatry the answer to medical dualism?" "The death of psychiatry." "The life of psychiatry." "Muddled models." "Labeling effects in psychiatric hospitalization." "The psychotherapy jungle—a guide for the perplexed." "Breaking through the boarding house blues." "Social policy in mental illness." "Shopping for the right therapy." "Is psychiatry a white middle-class invention?" "It's all in your head." "The future of psychoanalysis and its institutes." "The great megavitamin flap."

Much of what has been cited touches on the psychiatrist's professional role. To obtain a more immediate sampling, I asked 60 psychiatric colleagues and 12 psychologists, social workers, social scientists, and biologists to list what they considered the three most urgent problems confronting the psychiatric profession at this time. Here, as in the list of titles mentioned above, the psychiatric group's central and pervasive concern, in contrast to that of the nonpsychiatrists, was definition of their professional role. These psychiatrists—whether full-time or part-time, in

hospital or office practice, town or gown, junior or senior—asked, "Who am I? What knowledge and which skills shall I need in my professional work? Who will be my patients, and with whom do I share responsibility for the care of the sick?"

Many also sought clarification of their professional role, not only within the medical profession—as, for example, in the question, "Am I a real doctor?"—but also within the mental health team (psychologist, social worker, nurse, social scientist, mental health counselor, and others): "What do I do, and what do the others do?" No one has described our predicament more succinctly than Leon Eisenberg, who said,[2]

> Does psychiatry have a future as a medical specialty?....There are those who argue that mental disorders are simply forms of social deviance and that psychiatry is nothing more than a covert penal system, designed to maintain law and order. Others contend that mental ailments are problems of living and that people from his neighborhood are better able to treat the patient than doctors distant from him in status, education, and social class. Psychologists tell us that psychiatrists study medicine, which they do not practice, and practice psychology, which they have not studied.

Whether our concerns differ in kind or number from those of our predecessors in other times and places will be decided by tomorrow's historians. Silas Weir Mitchell's critique (1894) of the psychiatric profession[3] pointed to some of the deficiencies in the study and care of institutionalized patients at that time. Although certain matters of which he spoke are relevant in our day, we live in a different time and, for the most part, have quite different problems. Several colleagues have commented that this confusion as to our identity has been recognized as a problem among psychiatrists since at least World War II, if not before, and that similar confusion exists in the psychiatric professions of other nations. It is said that each generation is apt to overestimate its contribution to its society and, perhaps for the same reasons, to overestimate the seriousness of its problems.

But what has happened to us? Is our concern appropriate? What has contributed to this confusion about our professional role? It seems unlikely that whatever confusion we may have could be due in any serious degree to the inherent ambiguities of our material—human nature in distress. There is as yet no satisfactory unitary concept which encompasses human behavior in biological, psychological, and social terms. We have yet to acquire a full and proper language to deal with the whole of man in his society. We have withdrawn into secluded apartments in our Tower of Babel and at times speak to each other only in tongues. But this has been

so since the beginning, and I would expect it to be so for some time to come. Our colleagues in surgery and other branches of medicine are less concerned with this matter than they are with the seemingly infinite variations of human behavior in manners and morals. Thus, unlike most of our medical colleagues, we carry a heavier burden of doubt, conceptual uncertainty, or ambiguity.

I believe that our confusion has been determined by certain changes in the aims, scope, and operations of our professional work. These changes are not only of considerable magnitude, but have occurred at an unprecedented rate during these past 30 years. Because we are intimately intertwined with the society in which we exist and serve, the changes which have occurred in our field, as in all of medicine, obviously are part of a larger fabric. It is claimed that more basic and far-reaching changes have occurred in the middle third of our century than during the 300 years preceding it.[4] The Great Depression, World War II, the wars in Korea and Vietnam, the rise of new nations, the struggle for power, the spread of affluence, the technological revolutions in making, building, and distributing goods and services, the increase in world population, the explosion of knowledge, the serious attempts to insure a full measure of civil rights and opportunities for all of our citizens—these and other factors have significantly and materially affected our way of life. Moreover, during the past decade of discord and discontent we have witnessed a movement away from reason and toward mysticism, which appears to be nourished in an ambience of mistrust of authority figures and of the establishment. One is aware of this in attitudes toward government, the law, the church, and education, as well as toward medicine. That the best educated and most sophisticated generation of young Americans in history should be seriously interested in astrology, palmistry, numerology, and even witchcraft is certainly an enigma or major paradox of our time. It is as if George Bernard Shaw's caution,[5] "Every profession is a conspiracy against society," had been taken seriously. But there is little question that in the long run society determines the professions which serve it. Change is not always for the better. In my lifetime several developments—for example, the psychopathic hospital and the general hospital psychiatric unit, as well as the psychoanalytic movement—have not fulfilled our expectations. We have awakened to any number of false dawns, but there is little question that change certainly has influenced our present professional status.

I have chosen to consider those changes relating to the remarkable

increase in the number of psychiatrists; the changing character of the psychiatric patient, together with the exponential expansion of psychotherapeutic modes; our renewed interest in the study, care, and treatment of the psychotic patient; and the beginning development of scientific research.

Increase in Number of Psychiatrists

The national mental health law, passed by the 79th Congress in 1946, was perhaps the single most influential factor in producing change. The law provided generous financial support for both education and research. Certainly, this law effected the greatest change in our profession, namely, the increase in our numbers. In 1934, when I began my resident training in psychiatry at Yale University, the total membership of the American Psychiatric Association (A.P.A.) was 1,604. In 1939, when I assumed my first faculty appointment as an instructor at Harvard University, it was 2,235. It was 2,913 when I went to the University of Cincinnati in 1942 to head the department, and 4,010 in 1946, when I came to the University of Rochester. Bertram Brown recently has estimated that today there are 27,000 psychiatrists in the United States, which must include those who are not members of the A.P.A. Further, he estimates that by 1980 there will be 30,000 psychiatrists. Brown estimated that the United States has between one quarter and one third of the world's psychiatrists.[6] If this is so, there must have been a comparable increase in psychiatrists in many other nations. Thus, during my professional lifetime there has been, in the United States, an increase of psychiatrists from fewer than two per 100,000 population, to about 12 per 100,000, and Brown predicts 17.8 per 100,000 by 1980. All of this is quite a dry stick unless one has lived and worked and been accountable during the entire period. I grew up in Milwaukee and went to medical school at Marquette University, finishing in 1933. With the exception of one psychiatrist in the Child Guidance Clinic and two psychiatrists engaged principally in forensic work, the only other psychiatrists were in two small private psychiatric hospitals and two large county mental hospitals. The total number of psychiatrists was fewer than eight for the urban population of about 400,000. Today 94 psychiatrists serve only a doubled population in the same area. Similar growth took place in Cincinnati and Rochester. Neurotic patients, when identified and respected as such, were cared for by general practitioners, internists, and neurologists. I have no idea how often the alienist saw court cases, nor

how many children were seen in the guidance clinic. Psychotic patients, when identified, were sent to psychiatric hospitals.

And so, unlike 40 years ago, when the few psychiatrists who existed served almost exclusively in public and private mental hospitals, today's psychiatrists are found principally in community, private, and group practices; in clinics and general hospital settings, including those for children and adolescents: in schools, courts, and government agencies; and on the faculties of our medical schools, schools of social work, and at the National Institute of Mental Health (N.I.M.H.). The principal areas of neglect remain those of providing continuing care for chronic psychotic patients, alcoholic, drug-addicted, criminal, retarded, and aged patients—particularly when they are poor or black or both.

Psychiatry has become a house of many mansions, with considerable diversity among psychiatrists as to whom we see and care for, what methods we use, and what beliefs underlie our practices. Small wonder, then, that increasing numbers of patients are seen, estimated to be about five million, or more than 2.5% of the population each year.

But the story of this extraordinary increase is incomplete without mention of the parallel increase in numbers of our professional colleagues in the mental health field and a growing cadre of paraprofessional counselors. This, too, is in marked contrast with my experience as a resident when psychology and social work were represented by a few valiant souls who served principally as handmaidens. There were nurses—I learned much from them—and there were attendants in the large public hospitals. But now there are considerable numbers of psychologists, social workers, nurses, nurse-clinicians, nursing assistants, mental health counselors, and still others who share in the psychiatrist's care of his patient, not only on the inpatient services but in outpatient and office practices and in neighborhood outposts. Many assume duties which initially were fulfilled exclusively by psychiatrists. Obviously, there is confusion about this, and much of it stems from the lack of clear definitions of the roles of the nonmedical professional and paraprofessional people engaged in interdisciplinary involvement with psychiatric physicians. In this we are not alone. In October 1975 it was alleged that an ecumenical service was held in London by the Royal College of Psychiatrists, the Royal College of General Practitioners, the Association of Directors of Social Services, and the Department of Health and Social Security. The order of service was initiated by a reading from scripture:[7]

In the beginning, God made a psychiatric service and the psychiatrist ruled therein. And Lo! a psychiatric social worker was fashioned even from the psychiatrist's own rib. And they lived and worked happily together. Then there came a serpent and said to the woman: "Wherefore dost thou slave for this man? Social work should be generic. Behold, I bring thee a report which, if thou readest, will give thee greater wisdom and better conditions for service." And the woman did read and straightway she ran away to join others of her kind, Welfare workers, and Child workers, and Blind workers, and Old People's workers, each after her own kind. Then the psychiatrist was wroth and rent his raiment, and would not be comforted, except by a College.

And the confusion extends beyond the mental health team. If you listen carefully, you may hear a chorus of voices, often plaintive, sometimes petulant, but quite persistent, asking, "Who is my doctor?"

The Patient and Psychotherapy

Who is our patient? What do we understand to be the nature of his distress? Is his trouble to be considered disease or discontent? What can we do to help him? These are not trivial questions.

The Parsonian model of the "sick role,"[8] designed as a model of the acutely physically ill, is not useful when applied to psychiatric patients or patients with chronic illness. Most studies indicate that the extent of society's agreement about admission to the sick role decreases as social and psychological aspects of the condition increase. Obvious differences between these groups are based upon notions of individual responsibility for incapacity; the hazard, as well as the reward, for seeking technical professional help; and the dependent, passive, submissive versus independent, active, and self-directed interactions with the professional person.[9]

In our lifetime the model of acute physical illness has been applied to two great public mental health scourges—the psychoses associated with neurosyphilis and pellagra—now happily reduced if not eliminated. The traditional sick model also can be applied without much difficulty to the organic psychoses because these may be determined by genetic factors, infection, trauma, neoplasm, metabolic disorder, aging, etc., and, more recently, because the vigorous interest in genetics and neurochemistry and the successful use of the psychotropic drugs and other biochemical agents has placed greater emphasis on biological factors in explaining the onset, course, and treatment of schizophrenia, manic-depressive reactions, and many other affective disorders. There also has been a more critical view of the exclusively psychological explanation of certain of the neuroses, including the historical paradigm of hysteria.[10]

The principal thrust of the modern theory of psychological motivation emerged from Freud's study of neurotic patients, which draws attention to the conflict of competing needs and drives for expression or compromise. The counter-theory, more traditional with medicine, is the neurobiological concept which attempts to explain behavior in terms of deficit, impaired capacities, release or loss of controlled behavior, and the lowering of the organizational level. Each had its past in the mists of antiquity. We can find ancient allegations that disease or sickness may be related to fear, shame, guilt, or feelings of having done wrong, and we can trace our neurobiological concept of brain disease back at least to Hippocrates. On other occasions I have drawn attention to the impact of psychoanalysis on psychiatry in the United States, as contrasted with Europe, which, in turn, led to a wider polarization of belief systems among American psychiatrists as compared with our European colleagues.[11] We have championed the psychosocial model of behavior, at times to the detriment of the genetic biological model, and this has led us, quite predictably, to respond to a considerably broader variety of people in distress. Many psychotherapists in private practice were concerned principally with neurotic middle-class patients; however, the nature of the neurotic distress treated changed from symptom distress or symptom neurosis to character neurosis. This, in turn, expanded to responding to the needs of those who are unhappy, troubled, alienated, lonely, and afflicted with the malaise and anomie of our time.

Small wonder, then, that we have wandered far from our original aim: the art of treating mental disorders. Now we are concerned not only with the relief of distress, but with the achievement of positive mental health, and so the range of problems has expanded. Psychotherapy, as influenced by psychoanalytic psychology, was most concerned with the individual's internal unconscious conflicts, but now it attempts to change or to modify interpersonal and family relations and other social systems of which the patient is a member. Our students at times appear puzzled about the psychiatrist who once was known as Mr. Inside and now as Mr. Outside. I believe that man's problems always have been both inside and outside and I am somewhat dismayed at the exclusive commitment by some of our colleagues to one pole or the other. A plague on both their houses! There is little question in my mind that dynamic psychotherapy, as influenced by psychoanalytic psychology, has had a tremendous humanizing influence on all of medicine. It has helped inestimably in understanding one another and

our patients, and has made possible the beginning of a systematic approach to studying the interaction between patient and physician. Our increasing concern with the human family as well as the human community has added immeasurably to our understanding of the human condition.

Psychotherapy, formerly a province of psychiatrists and psychoanalysts, now encompasses clinical psychologists, social workers, nurses, clergymen, and a large group of paraprofessionals. Some former patients also are included; their credentials as psychotherapists are that they have experienced distress similar to that experienced by those for whom they care—particularly drug abusers, alcoholics, delinquents, and criminals. We are told that at the moment there are 130 different psychotherapeutic modes. Parloff, in a splendid popular presentation,[12] has classified the four major schools: 1) analytically oriented therapy, 2) behavioral therapy, 3) humanistic therapy, and 4) transpersonal therapy. Others, such as many group and community-oriented therapies, may be classified as pantheoretical, and still others, such as primal therapy, defy classification. The first two of the major schools, namely, analytically oriented therapy and behavioral therapy, hardly need explanation. Humanistic therapy is represented by a broad spectrum of self-actualizing techniques.

Transpersonalists are not content with the aims of self-actualization. Their goal, as usually phrased, is to transcend the limits of ordinary waking consciousness and to become at one with the universe. I did not realize how extensively certain of these methods were used until I read a brief report of a recent Gallup Poll in the *New York Times*.[13] A sampling of 1,553 adults, 18 years of age or older, during August 27-30, 1976, were given a card which listed various disciplines and were asked, "Which, if any, of these are you involved in, or do you practice?" The list included mysticism, oriental religions, yoga, transcendental meditation, and charismatic renewal (a Christian movement that emphasizes the gifts of the spirit, such as healing and speaking in tongues). Transcendental meditation registered the greatest following, 4% of those sampled, or an estimated six million people in the United States. Next was yoga, which attained a 3% response, for a projected total of five million people. Charismatic renewal and mysticism each gained 2% of the responses, or an estimated three million people. One percent of the sample, or a projected total of two million people, indicated an association with Eastern religions. The report concluded that those who practiced transcendental meditation and yoga tended to be young adults 18 to 24 years of age, college students, or those

generally nonreligious in the traditional sense. These findings were attributed to two social trends:[13] "...one is the apparent desire by many Americans to find ways of calming the tensions of modern life, the other is that the new wave represents a revolt against the scientific rationalistic view that has created a profoundly secular climate."

Obviously, today's psychiatrist is not the only professional, paraprofessional, or lay person engaged in these matters. But there is little question that considerable changes have occurred in the aims and scope of patients and the population of patients served today as compared with 30 to 40 years ago. Most of us would accept the evidence that almost all forms of psychotherapy are effective for about two thirds of the nonpsychotic patients treated, regardless of method, and that treated patients show more improvement in mood, thought, and behavior than do comparable samples of untreated patients. It is said that behavior modification appears to be particularly useful in some specific types of phobias, but, thus far, there is no convincing evidence of relief provided by biofeedback, and I know of no critical studies of the effectiveness of the many humanistic and transpersonal therapeutic modes.

With increased numbers, a parallel increase in nonmedical and paraprofessional groups, and the increasing breadth of human problems being brought to our attention, confusion about the designation of those who seek help is not surprising. Traditionally, in the medical sense, one who seeks help is a patient or a person who suffers. But, increasingly, those who seek help, regardless of from whom, are called clients, a term which initially meant a dependent, and customarily refers to those served by a social agency or legal advisor. Some of the objectives of the transpersonalists and humanists might cause one to wonder whether those who seek such help should be called penitents.

There is so much more for psychiatrists to learn about this incredibly important and influential phenomenon which takes place between the patient (the one who suffers) and the physician (the one who wishes to heal). This has been the thread of continuity, the means of survival, of the physician through the centuries, regardless of how informed or uninformed and how helpful or harmful he has been to those who sought his aid.

Perhaps Jerome Frank was right in proposing the following six features as common to all psychotherapies:[14]

1) An intense, emotionally charged, confiding relationship with a helping person, often with the participation of a group.

2) A rationale or myth which includes an explanation of the cause of the patient's distress and a method for relieving it

3) Provision of new information concerning the nature and sources of the patient's problems and possible alternative ways of dealing with them

4) Strengthening the patient's expectations of help through the personal qualities of the therapist, enhanced by his status in society and the setting in which he works

5) Provision of success experiences which further heighten the patient's hopes and also enhance his sense of mastery, interpersonal competence, or capability

6) The sixth shared feature of all psychotherapies is facilitation of emotional arousal, which seems to be a prerequisite to attitudinal and behavioral changes

Obviously, a major area of unfinished business is the search for that which is basic and essential to the psychotherapeutic encounter. Psychiatrists—with their colleagues in psychology, biology, and the social sciences—must pursue with increasing vigor those studies which one day may enable us to act less blindly and to prescribe the appropriate method to help our patients.

Psychotic Patients

One of the more dramatic changes during the past 30 years has been renewed interest in the care and treatment of psychotic patients. Professional journal reports attest to the reduction of the resident populations of state and county mental hospitals, the decline in the average length of stay, and the shift away from institutional care toward care in psychiatric units of general hospitals and beyond, in outpatient departments and private practitioners' offices. There were several determinants, but the changes stemmed principally from psychotropic drugs and the re-emergence from the past of the moral treatment of psychotic patients. Although we are aware of the limitations of each of these, there has been a remarkable change from the days when many treatments were used and the psychiatric hospitals were filled with long-term patients. We fully used the therapeutic enthusiasms of our day, with dauerschlaf, insulin, pentavalent arsenicals, and Kettering hypertherm. We used choral, bromides, and barbiturates as wisely as we knew how, and we practiced the various types of insight and supportive psychotherapies known at that time. Sulpha had just arrived, penicillin was yet to come, and we would wait 20 years before chlorpromazine was available. Later, Metrazol was used, electroconvulsive therapy was on the horizon. We seemed to have endless numbers of acutely disturbed patients, and psychiatrists, nurses, and attendants would respond to their emergency needs like seasoned firehorses. We did begin

certain limited community services; for example, we helped to establish outpost clinics in western Colorado for triage, diagnostic study, first-aid treatment, and referral. Although psychotropic drugs have altered materially the course and recurrence of psychotic episodes, they are, in themselves, no full solution to psychosis and often cause toxic reactions, even when prescribed appropriately.

I look upon the community mental health movement in principle as a vanguard of what will be taking place in all of medicine. It reflects our increasing concern with the delivery of health services, awareness of our current deficiencies in the continuing care of our patients, and concern with the pervasive problems of the much-neglected chronically ill patient.

Regrettably, the initial phases of this movement were launched without adequate systematic experiment and trial, and, as a result, many chronic psychotic patients, who had been long institutionalized, with absent or long-lost social skills, were catapulted into the community without adequate means for their care. Chronic illness is not a myth, and cannot be removed by sweeping it under the rug of ill-prepared facilities.

While these two movements in concert have brought about dramatic change in the care of psychotic patients, in themselves they have led to quite divergent goals.

The introduction of drugs and their daily use by practicing psychiatrists has returned psychiatrists to their biological heritage and drawn attention to neurobiological as well as motivational models as determinants of illness. This has led to a more balanced view of psychopathology, explicable not only in the paradigmatic terms of psychologic conflict, but in terms of deficit. The daily use of medication has required physical as well as psychological screening of patients, and the psychiatrist has had to become familiar with certain laboratory methods to help him gauge drug dosage and avoid complications. This trend has been called neo-Kraepelinian, with serious consideration of genetic factors, greater precision in noting signs and symptoms of disease, charting of the natural course of illness, and follow-up studies of the effects of intervention on prognosis. In short, the psychiatrist is again a doctor. But, alas, amid all of this our colleagues on the American Board of Psychiatry and Neurology decided in 1970 to eliminate the one-year internship requirement for certification in psychiatry and neurology. For those of us who have devoted most of our professional lives to strengthening the relations between psychiatry and medicine, this decision seemed regressive.[15] I am heartened to learn that movements exist to correct this error in judgment, at least in part.

The community health movement has pointed in another direction. It has led some to insist that our major objectives must be those of primary prevention, that is, that the psychiatrist become informed and socially and politically active in reducing poverty, population increase, and racial discrimination, and in improving education, employment, and housing. This constitutes a major departure from our traditional engagement with the individual patient, and points toward a collective public health-social engineering role for the psychiatrist which I believe makes demands which he cannot fulfill because of lack of expertness in social and political science. This, regrettably, is documented clearly by several instances of our bumbling political intervention in community mental health ventures.

From an educational point of view, I believe this dilemma causes the most confusion among our young residents. We have, as yet, no clear definitions of public health, social, and political roles to guide the preparation of those who may assume these new responsibilities. We have erred in promising not one but many rose gardens in response to society's insistent demands that we reduce crime, delinquency, drug abuse, and alcoholism.

RESEARCH

I agree with Lewis Thomas that our most urgent problem is to insure continued and vigorous support of research in all fields relevant to our professional work.[16] Particularly those inquiries that may lead to basic or fundamental knowledge must be supported, and not merely those which may have immediate applicability for personal and social change. We must insure support and facilities to pursue new knowledge, including some which may seem useless at the moment. We must remember that we have just begun. Henry E. Sigerist reminded us that the physician was a priest in Babylonia, a craftsman in Ancient Greece, a cleric in the early Middle Ages, and a scholar in the late Middle Ages. The physician became a scientist with the rise of the natural sciences barely a century ago. We stand at a beginning.

During my internship, residency, and fellowship assignments in New Haven, Denver, and Boston, no formal investigative work was going on, although several of us became involved in clinical case histories and follow-up studies. Few scientific investigators were available as models. At that time psychiatry had no Rockefeller Institute to groom young professors, as was the case in medicine and physiology. We had to wait

almost 15 years before N.I.M.H. became a reality. Our model was the clinician, teacher, and scholar, and later the psychoanalytic psychotherapist-practitioner. Not until the early 1950s was the Career Investigator Fellowship Program established by N.I.M.H., with the hope of several of us that a new model of psychiatrist-scientific investigator would be created and fostered.

Robert Morison, in his critique of our field of more than a decade ago, reminded us of the contributions of the Rockefeller Foundation before the establishment of N.I.M.H. He pointed out how sparse the money was:[17]

> ...a little over $16,000,000 in twenty years for Psychiatry and related disciplines. The related disciplines (Neurology, Neurophysiology, Neuroanatomy, Neurochemistry, and Psychology) absorbed nearly two-thirds of the funds. Virtually all of the research supported during this period was in the related disciplines and not in Psychiatry per se. Help to Psychiatry, itself, went largely for the development of full-time teaching departments in medical schools, with smaller portions to training fellowships and some experiments in the application of Psychiatry as in mental health and child guidance clinics. Emphasis in the teaching departments was on bringing this specialty more fully into the mainstream of Medicine.

More recently, Brown summarized a two-year report of the Research Task Force* that involved 300 people and $1 million and reviewed $1 billion worth of research in the United States supported by N.I.M.H. and other groups. The number of research projects supported annually by N.I.M.H. has grown from 38 in 1948, when the first appropriations were made under the National Mental Health Act of 1946 (I was privileged to serve as chairman of the first Research Study Section), to nearly 1,500 in 1975. The report indicates that over the last 20 years the ratio of N.I.M.H. supported biomedical research to psychosocial research was reversed. Twenty years ago the ratio of biomedical to psychosocial research was two to one; in 1972 it was one to two, a change which reflects broadening of commitments in the late 1960s to such social problem areas as crime and delinquency.[6]

During my recent return to clinical research, after many intervening years as department chairman, I noted certain changes in clinical investigation.[18] I noted that only a limited number of clinical psychiatrists are engaged in basic or applied clinical research today. For example, among a sample of 20 ongoing programs in the United States studying the antecedents of schizophrenia, I found only seven with psychiatrists as principal

*One of the three committees which reported to the National Mental Health Council. The other committees were the Training Committee and the Community Service Committee.

investigators; the rest were headed by psychologists. Not to disparage the considerable contributions made by our psychologist colleagues, I found it somewhat disappointing that more psychiatrists are not engaged in full-time research, particularly after the aspirations of those who initiated the Career Investigator Program of the Public Health Service more than 20 years ago. From what Brown has written, I gather that my sample may be valid for the nation as a whole. He said:[6]

Psychiatry has been a major service-providing instrument of that vital and nourishing enterprise we çall mental health research. The psychiatrist has played a significant but smaller role in the actual conduct of research. Only a few psychiatrists—numbering the hundreds—are full-time researchers.

I have begun to understand better the separate domains of clinician and investigator, and, at times, how difficult it may be for one to understand the other. The investigator defines in clear, operational terms the variables he wishes to test. His view is apt to be circumscribed or atomic, as contrasted with the molar, full sweep of the clinician. The investigator points toward behavior of members of a class, the nomothetic position, while the clinician has been traditionally idiographic. The investigator, because of the circumscribed sample, is ahistoric, while the clinician's hallmark has been his allegiance to the historic method. Finally, the clinician's therapeutic intent demarcates him from his investigator colleague's basic curiosity. Many years ago I drew attention to other factors which may have contributed to the lag in psychiatric research, as compared with the pursuit of new knowledge in other medical fields.[19]

I also have other impressions. It seems that few senior professional people have direct contact with research subjects or patients. Research based on chart review has limited utility; the habit of recording data in terms of inferred psychodynamics rather than at the phenotypic levels of behavior is lamentable. I have noted the growing temptation to use methods which are familiar, available, and reliable, but are inappropriate to test what we wish to learn, confusion between the investigative purposes of generating a hypothesis and testing a hypothesis, and an awesome regard for the all-inclusive and seemingly infinite capacities of the computer.

Of the utmost importance to our university departments of psychiatry should be the existence and support of adequate role models who are significantly and seriously engaged in research; opportunities should be made for college, medical, psychology, social science, and biology students, and particularly for psychiatric residents to be exposed to the lives,

interests, and work of research scientists. Every attempt also should be made to identify the special talents of the young and to nourish them with fellowship assistance.

Conclusion

It is quite fashionable today to be concerned with death and dying. Even after applying our new and more precise tests, we need not chant a requiem Mass for the repose of the soul of psychiatry. However, it is time to sound reveille, to call the profession to rise to fulfill our professional responsibilities more effectively.

Psychiatry has become diverse, not quite as diverse as our older brothers the internists and surgeons, but more so than the pediatricians and obstetricians, whom we now outnumber. This diversity is essentially a function of numbers, but is further qualified by an increasing fragmentation of the functions formerly performed by our generalists. Full-time psychiatric faculty members in medical schools have increased exponentially and are exceeded only by those in internal medicine (although the number of psychiatrists engaged in full-time research is small in comparison). The demand for our consultative services from health, welfare, and legal agencies, both public and private, continues. The explosive multiplication of psychotherapeutic modes has further fragmented our profession, although many, if not most, of the newer techniques have been initiated by nonpsychiatrists who assume the greater share of behavioristic, humanistic, and transpersonal therapeutic approaches, particularly in group sessions.

I am heartened by the renewed interest in psychotic patients and their families, an interest nourished by psychotropic drugs and their serendipitous impact on neurochemical research and by the moral treatment of our day, with its compassionate concern for forgotten and neglected chronic patients. We have learned that psychopathology survives and prospers under many flags and that behavior can be explicable in terms of deficit as well as conflict. One of our greatest achievements has been the education of all medical students, whether or not their major concern in later life will be in the care of patients. Consider how significant this is now and how significant it may become should there be continued development of family-medicine and primary-care physician programs. I mentioned the imperative need to pursue new knowledge so that one day we may better understand the essence of psychopathology and psychotherapy.

At times I am reminded of the immortal words of Pogo, the cartoon character, "We have met the enemy and he is us." Obviously, we erred in our uncritical, naive, and passive obeisance to political pressure when we embarked on community mental-health ventures without adequate and systematic trial. Our decision to eliminate the standing internship for professional training was peremptory, thereby risking our biological heritage. We must clarify our roles and the roles of others, both professional and paraprofessional, who share the study, care, and treatment of the sick and their families. Our present deceptive egalitarianism has led to confusion worse confounded, and, in practice, has led to the lowest common denominator of skill.

We must stop acting blindly as self-appointed social-engineer-saviors and learn from experiment and trial whether and how our skills and knowledge are applicable to social issues. We should examine carefully our relations to the law, the courts, and the criminal. We may have promised more than we were able to give, but there is little question that we have added considerably to the humanizing of criminal justice in our search for the psychological antecedents of deviant behavior.

In the present ambience of mistrust, we must do all we can to earn the confidence of our patients and their families to insure privacy and, above all, to do no harm. We should not be intimidated by the strident abstractions of those who would prevent us and our patients from knowing more; the right to know is as fundamental as the right to live.

We are overdirected, overmanaged, overburdened, and almost overcome by a militant corps of congressmen, lawyers, judges, philosophers, clergymen, ethicists, and paraprofessional do-gooders who are unrestrained in their zeal to tell us whom we are to see, what medications we are to prescribe when, whom we should admit to hospitals, how long they should stay, and which questions we should ask—unprecedented intrusions. In an historical sense this is all quite interesting, because for decades our patients and profession have been unsung, unloved, and unheard of. Usually swept under the rug of collective shame and guilt, we now stagger unsteadily through a forest of committees intent on insuring that we are dependable, responsible, and accountable. I prefer as my guides the moral dicta of earlier days, taught by Hippocrates and Maimonides.

I would commend to you the clear, vigorous statement made recently by Jonas R. Rappeport,[20] in which he suggests that we

...declare a type of independence from the law, that we declare our individuality, that we declare the rationality of our treatment programs, the rationality of our need to commit some patients to hospitals, that we declare that commitment laws fit the needs of patients, not abstract concepts—and our right to treat patients at the best possible facilities and in the best manner, according to our professional judgment, without costly and wasteful legal trappings.

At the bicentennary celebration of the first public mental health hospital in the colonies, at Williamsburg, Va., in 1973 I said:[11]

The major function of the psychiatrist, and one unique to him, is that he serves as a crucial bridge between genetics, biology, and clinical medicine, on one hand, and the behavioral sciences on the other. The psychologist, the social worker, and the social scientist lack knowledge of the body, the biologist that of the mind, and up to the present, the nurse has had insufficient scholarship in either field to serve the purpose of a bridge. Further, I believe that if we are to serve this function properly, we must become expert in both biologic and psychosocial systems. Only then will we be able to interrelate effectively the knowledge from these basic sources in our unique role and contribution as clinician and scientist. To neglect scholarship at either pole would be to diminish our usefulness for tomorrow.

While we may derive knowledge from the biologic and psychosocial systems, we must also contribute to them. We can do this best in our historic and essential role as psychiatric clinicians. Let us hope that those who teach our successors will keep this point foremost, and will be constantly dissatisfied with customary procedures in their search to organize and use intelligence in new ways. Such a search may help us to learn what is basic and essential to our task, that which may be found appropriate and useful to our purpose and to the changing needs of our society. There is so much to learn, so very much yet to be discovered. Lacking a bugle to sound reveille, I quote Sir Rabindrath Tagore, the late Indian author and poet:

Listen to the rumbling of the clouds, O heart of mine,
Be brave, break through, and leave for the unknown.

REFERENCES

1. Murphy, J. M.: Psychiatric labeling in cross-cultural perspective. *Science 191*:1019-28, 1976.
2. Eisenberg, L.: The future of psychiatry. *Lancet 2*:1371-75, 1973.
3. Mitchell, S. W.: Address before the Fiftieth Annual Meeting of the American Medico-Psychological Association. *J. Nerv. Ment. Dis. 21*:413-37, 1894.
4. Romano, J.: Twenty-five years of university department chairmanship. *Am. J. Psychiatry* (Suppl.) *122*:7-27, 1966.
5. Shaw, G. B.: *The Doctor's Dilemma*. Harmondsworth, Penguin, 1948, pp. 15, 16.
6. Brown, B. S.: The life of psychiatry. *Am. J. Psychiatry 133*:489-95, 1976.
7. Birley, J. L. T.: Ecumenism in action. *Br. J. Psychiatry 129*:7-8, 1976.

8. Parsons, T.: *The Social System.* Glencoe, Ill., Free Press, 1951.
9. Segall, A.: The sick role concept: Understanding illness behavior. *J. Health Soc. Behav. 17*:162-69, 1976.
10. Ludwig, A. M.: Hysteria, a neurobiological theory. *Arch. Gen. Psychiatry 27*:771-77, 1972.
11. Romano, J.: *American Psychiatry: Past, Present, and Future,* Kriegman, G., Gardner, R. D., and Abse, D. W., editors. Charlottesville, Va., University of Virginia Press, 1975, pp. 28-44.
12. Parloff, M. B.: Shopping for the right therapy. *Saturday Rev.* 14-20, February 21, 1976.
13. Meditation, yoga, mysticism said to be gaining popularity in the U. S. *New York Times,* November 18, 1976.
14. Frank, J. D.: Common features of psychotherapy. *Aust. N. Z. J. Psychiatry 6*:34-40, 1972.
15. Romano, J.: The elimination of the internship—An act of regression. *Am. J. Psychiatry 126*:1565-76, 1970.
16. Thomas, L., quoted by Wykert, J.: *Psychiatric News 11*:8-9, 1976.
17. Morison, R. S.: Some illnesses of mental health. *J. Med. Educ. 39*:985-99, 1964.
18. Romano, J.: The Central Core of Madness. *Proc. Second Rochester International Conference on Schizophrenia.* New York, Wiley, 1977.
19. Romano, J.: Discussion of paper by Brosin, H. W. Discovery and experiment in psychiatry. *Am. J. Psychiatry 111*:570-72, 1955.
20. Rappeport, J. R.: The belegaled profession. Roche report. *Frontiers Psychiatry 6*:1,5, 1976.